Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pain & Recovery Clinic

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-14-1361-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
January 16, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier has failed to recognize that all the dates of service were authorized by their utilization review department (ACE-ESIS). We corrected modifiers on our reconsideration request. And our services were authorized which means that it is not subject to retrospective review (peer review) and in violation of Pre-Authorization Rule 134.600. "

Amount in Dispute: $6,635.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that EIS Med Bill Impact will stand on the original recommendation of $0.00"

Response Submitted by: ESIS, 1851 E 1st St #200, Santa Ana, CA 92705

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 29, 2012 through February 8, 2013	Radiology, Physical Therapy Services	$6,635.00	$1,748.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out guidelines for prospective and concurrent review of healthcare.
3. 28 Texas Administrative Code §133.20 sets out requirements related to billing forms and formats.
4. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization/notification absent
   - 18 – Exact duplicate claim/service
   - 4 – The procedure code is inconsistent with the modifier used or required modifier is missing

- 193 – Original payment decision is being maintained
- W9 – Unnecessary treatment with peer review

Issues

1. Did the requestor submit the claim in compliance with Division guidelines?
2. Are services in dispute subject to prior authorized?
3. Can a prior authorization be withdrawn?
4. What is the applicable rule pertaining to reimbursement?
5. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied disputed services as 4 – "The procedure code is inconsistent with the modifier used or required modifier is missing." Per 28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers…" Centers for Medicare and Medicaid Services, Claims Processing Manual, Chapter 5, Section 10.4(Rev. 2073, Issued:10-22-10, Effective: 01-01-11, Implementation: 01-03-11) B. Requirements - Carrier or A/B Mac states in pertinent part, "Claims containing any of the "always therapy" codes should have one of the therapy modifiers appended (GN, GO, GP)." A list may be found at, http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html. Review of the submitted medical claims finds the following;

Date of Service	Submitted code/modifier	Always therapy code?	Was modifier required?	Supporting Evidence (claim) modifier used?	Eligible for payment?
December 12, 2012	97110	Yes	Yes	No	No
December 12, 2012	97140	Yes	Yes	No	No
December 12, 2012	97112	Yes	Yes	No	No
December 12, 2012	97014 , GP	No	No	Yes	No, code not recognized by Medicare
December 14, 2012	97110	Yes	Yes	No	No
December 14, 2012	97140	Yes	Yes	No	No
December 14, 2012	97112	Yes	Yes	No	No
December 14, 2012	97014 , GP	No	No	Yes	No, code not recognized by Medicare
December 20, 2012	97110	Yes	Yes	No	No
December 20, 2012	97140	Yes	Yes	No	No
December 20, 2012	97112	Yes	Yes	No	No
December 20, 2012	97014 , GP	No	No	Yes	No, code not recognized by Medicare
December 21, 2012	97110	Yes	Yes	No	No
December 21, 2012	97140	Yes	Yes	No	No
December 21, 2012	97112	Yes	Yes	No	No
December 21, 2012	97014 , GP	No	No	Yes	No, code not recognized by Medicare
December 22, 2012	97110	Yes	Yes	No	No
December 22, 2012	97140	Yes	Yes	No	No
December 22, 2012	97112	Yes	Yes	No	No
December 22, 2012	97014 , GP	No	No	Yes	No, code not recognized by Medicare

Based on the above the carrier's denial for these dates of service is supported. No payment can be recommended.

2. Per 28 Texas Administrative Code 134.600 (p) states in pertinent part, "Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed

in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation," and (8) "unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline; or (B) without a reimbursement rate established in the current Medical Fee Guideline;".

The carrier denied medical bill with dates of service 11/29/2012 for codes 72072, 72100 and 73030 as, 197 – "Precertification/authorization/notification absent " per Rule 134.600 (p) (8), prior authorization is only required if the services performed has a reimbursement rate of greater than $350. Review of the applicable fee schedule finds they do not. The carrier's denial is not supported.

28 Texas Administrative Code §134.203 (c) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor). The claim in question will be calculated as follows;

(TDI-DWC Conversion Factor / Medicare Conversion Factor) x Non-Facility Price = MAR

72072 (54.86 / 34.0376) x 38.20 = $61.57

72100 (54.86 / 34.0376) x 37.80 = $60.92

73030 (54.86 / 34.0376) x 31.65 = $51.01

Total = $173.50

The total allowable for these services is $173.50. This amount is recommended.

3. The carrier denied claims with date rage January 30, 2013 through February 8, 2013 as W9 – "Unnecessary treatment with peer review." Review of the submitted information finds;
    a. Document from ACE/esis dated December 11, 2012, Review 140332: 12 sessions of active physical rehabilitation for the right shoulder between 12/01/2012 and 2/8/2013 is certified
    b. Document from ACE/esis dated January 8, 2013, Review 142211. 12 sessions of Active Physical Rehabilitation for Lumbar Spine between 1/7/2013 and 3/8/2013 is certified.

    28 Texas Administrative Code §134.600 (l) states in pertinent part, "The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued." Review of the above finds services related to physical therapy were prior authorized therefore; the Carrier's denial is not supported. These services will be reviewed per applicable rules and fee guidelines.
4. 28 Texas Administrative Code §134.203 (c) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor). The maximum allowable reimbursement will be calculated as follows;

Date of Service	Submitted Code	Units	Maximum Allowable Reimbursement
January 30, 2013	97110	3	(54.86 / 34.0376) x 32.13 = $51.79 x 3 = $155.37
January 30, 2013	97140	2	(54.86 / 34.0376) x 33.49 = $53.98 x 2 = $107.96
January 30, 2013	97112	1	(54.86 / 34.0376) x 32.08 x 1 = $51.70
January 30, 2013	97014	1	97014 -- electrical stimulation unattended (NOTE: 97014 is not recognized by Medicare. Use G0283 when reporting unattended electrical stimulation for other than wound care purposes
February 1, 2013	97110	3	(54.86 / 34.0376) x 32.13 = $51.79 x 3 = $155.37
February 1, 2013	97140	2	(54.86 / 34.0376) x 33.49 = $53.98 x 2 = $107.96
February 1, 2013	97112	1	(54.86 / 34.0376) x 32.08 x 1 = $51.70
February 1, 2013	97014	1	97014 -- electrical stimulation unattended (NOTE: 97014 is not recognized by Medicare. Use G0283 when reporting unattended electrical stimulation for other than wound care purposes
February 5, 2013	97110	3	(54.86 / 34.0376) x 32.13 = $51.79 x 3 = $155.37
February 5, 2013	97140	2	(54.86 / 34.0376) x 33.49 = $53.98 x 2 = $107.96
February 5, 2013	97112	1	(54.86 / 34.0376) x 32.08 x 1 = $51.70
February 5, 2013	97014	1	97014 -- electrical stimulation unattended (NOTE: 97014 is not recognized by Medicare. Use G0283 when reporting unattended electrical stimulation for other than wound care purposes
February 6, 2013	97110	3	(54.86 / 34.0376) x 32.13 = $51.79 x 3 = $155.37

February 6, 2013	97140	2	(54.86 / 34.0376) x 33.49 = $53.98 x 2 = $107.96
February 6, 2013	97112	1	(54.86 / 34.0376) x 32.08 x 1 = $51.70
February 6, 2013	97014	1	97014 -- electrical stimulation unattended (NOTE: 97014 is not recognized by Medicare. Use G0283 when reporting unattended electrical stimulation for other than wound care purposes
February 8, 2013	97110	3	(54.86 / 34.0376) x 32.13 = $51.79 x 3 = $155.37
February 8, 2013	97140	2	(54.86 / 34.0376) x 33.49 = $53.98 x 2 = $107.96
February 8, 2013	97112	1	(54.86 / 34.0376) x 32.08 x 1 = $51.70
February 8, 2013	97014	1	97014 -- electrical stimulation unattended (NOTE: 97014 is not recognized by Medicare. Use G0283 when reporting unattended electrical stimulation for other than wound care purposes
		Total	$1,575.15

The total allowable reimbursement for these services is $1,575.15. This amount is recommended

5. The total recommended payment for the services in dispute is ($173.50 + 1,575.15) = $1,748.65. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $1,748.65. This amount is recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,748.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,748.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature — Medical Fee Dispute Resolution Officer — March 12, 2015 (Date)

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.